TRILLIUM EYE CARE

PATIENT INFORMATION

Today's Date: _____

First Name: _____ Last Name: _____ DOB_____Gender:__M / F / N_____

Address: _____City: _____ Prov:_____ Postal Code:_____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

How did you hear about us? (check one):

☐ Google/Web ☐ Passing by ☐ Family/Friend ☐ Event ☐ Patient ☐ Physician ☐Insurance ☐Other: _____

☐ **I agree to receive Trillium Eye Care appointment reminders. I prefer to be contacted by ☐email, ☐phone, ☐text or ☐any of these. We may also send you important information about developments, promotions and publications. We protect your information; please refer to our Privacy Policy available online. You may withdraw your consent at anytime.**

INSURANCE

Primary Medical Insurance: _____ Policy#_____ Group #_____

Secondary Medical Insurance: _____ Policy#_____ Group #_____

Subscribers Name: _____ DOB_____ Relationship to Patient_____

OHIP Number: _____ VC: _____ Expiration Date: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above insurance plans and assign directly to Trillium Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, except those covered by OHIP. I authorize the use of my signature on all insurance submissions. Trillium Eye Care may use my health care information and may disclose such information to the above-named insurance plans and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

PERSONAL HEALTH INFORMATION CONSENT FORM/PHIPA

Your information is shared among your doctors and medical associates to provide you with health care. Your personal information must be kept private and confidential, but maybe disclosed by us for the following purposes:

- Provide health care and assistance
- Communicate with other medical personal where external care maybe required
- Obtain payment for your health care
- Conduct office planning and procedures to improve patient care
- Report information as maybe required or permitted by the law

I acknowledge that I been provided with a copy of the *Patient Personal Health Information Guide* (the "Guide"). I have reviewed and understand the Guide which describes the purposes for the collection, use and disclosure of my personal health information. I personally give my knowing and voluntary consent for the collection, use and disclosure of such information. I understand that my consent can be withheld or withdrawn at any time.

I _____, hereby give my express written consent to Trillium Eye Care to collect, use and disclose my (or in such cases, on behalf of another as the authorized substituted decision maker) personal health information as maybe required pursuant to the *Personal Health Information Protection Act, S.O. 2004 (PHIPA)* for the purposes of receiving medical care.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

VISUAL & HEALTH HISTORY

Date of **last eye exam**:_____ By Whom: _____

Type of exam you desire today (please circle): **Eye Health** **Glasses** **Contacts** **All listed**

What visual problems are you having, or what brings you here today? _____

Family Practitioner:_____ Address: _____

Phone Number:_____Fax Number:_____Date of Last Visit:_____

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VISUAL & HEALTH HISTORY

Do you currently wear glasses? ☐yes ☐ no. Are you happy with the vision in your current glasses? ☐yes ☐ no

Do you currently participate in any of these activities? If yes, please indicate the amount of hours spent each day?

Driving? ☐yes ☐ no ____ hours per day Reading? ☐yes, ☐ no. ____ hours per day

Computer? ☐yes ☐no ____ hours per day Television? ☐yes ☐ no ____ hours per day

Do you currently wear contact lenses? ☐ yes ☐ no

If yes, please rate the comfort of your current lenses: (1 = poor comfort, 5 = excellent comfort) 1 2 3 4 5

What removal schedule do you follow? ☐ Daily removal ☐ Overnight wear

If you do not currently wear contact lenses, would you be interested in trying them? ☐yes ☐ no

REVIEW OF SYSTEMS

CONSTITUTIONAL	Yes	No
• Cancer	☐	☐
• Developmental Disabilities	☐	☐
NEUROLOGICAL		
• Tumor	☐	☐
• Multiple Sclerosis	☐	☐
• Stroke/CVA	☐	☐
• Migraine /Headaches	☐	☐
CARDIOVASCULAR		
• Congestive Heart Failure	☐	☐
• High Blood Pressure	☐	☐
• Heart Disease	☐	☐
RESPIRATORY		
• Asthma	☐	☐

GENITOURINARY	Yes	No
• Pregnant (currently)	☐	☐
• Nursing (currently)	☐	☐
• Herpes/Shingles	☐	☐
• HIV/AIDS	☐	☐
MUSCULOSKELETAL		
• Fibromyalgia	☐	☐
• Arthritis	☐	☐
ENDOCRINE		
• Thyroid Dysfunction	☐	☐
• Diabetes Mellitus		
○ Type 1	☐	☐
○ Type 2	☐	☐
HEMOTOLIGIC/LYMPHATIC		
• High Cholesterol	☐	☐
• Anemia	☐	☐

EYES	Yes	No
• Retinal Hole /Detachment	☐	☐
• Cataract	☐	☐
• Injury	☐	☐
• Glaucoma	☐	☐
• Dry Eye	☐	☐
• Inflammatory Disorder	☐	☐
• Eye Turn	☐	☐
• Macular Degeneration	☐	☐
• Surgery	☐	☐
• Keratoconus	☐	☐
• Changes in Vision	☐	☐
• Flashes of Light	☐	☐
• Floaters	☐	☐

OTHER HEALTH CONCERN_____

ALLERGIES: Medication Yes☐ No☐ Environmental Yes☐ No☐ Food Yes☐ No☐ Latex Yes☐ No☐

If yes, please specify: _____

MEDICATIONS: List all medications you are currently taking _____

_____

SOCIAL HISTORY

This information is kept strictly confidential.

Do you drive? ☐Yes ☐No If yes, do you have visual difficulty when driving? ☐Yes ☐No

If yes, please describe: Do you drink alcohol? ☐Yes ☐No If yes, type/amount/how long: _____

Do you CURRENTLY use tobacco products? ☐Yes ☐No Have you previously used tobacco products? ☐Yes ☐No

If you currently use tobacco products how frequent/amount: _____

Hobbies:_____ Sports:_____

FAMILY HISTORY

Does anyone in your family currently, or have they ever had any problems in the following areas? If yes, who?:

	Yes	No	Family Member
• Respiratory Problems	☐	☐	_____
• Cancer	☐	☐	_____
• Diabetes	☐	☐	_____
• High Blood Pressure	☐	☐	_____
• Heart Problems	☐	☐	_____
• Thyroid Dysfunction	☐	☐	_____
• High Cholesterol	☐	☐	_____

	Yes	No	Family Member
• Loss of Vision/Blindness	☐	☐	_____
• Macular Degeneration	☐	☐	_____
• Cataract	☐	☐	_____
• Glaucoma	☐	☐	_____
• Eye Turn/Lazy Eye	☐	☐	_____
• Retinal Detachment	☐	☐	_____